R590. Insurance, Administration. (*Effective 12-8-2011*)
R590-192. Unfair Accident and Health Claims Settlement Practices.
R590-192-1. Authority.

This rule is promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce Title 31A and to make rules to implement the provisions of Title 31A. Further authority to provide for timely settlement of claims is provided by Subsection 31A-26-301(1). Matters relating to proof and notice of loss are promulgated pursuant to Section 31A-26-301 and Subsection 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Subsection 31A-26-303(4). The authority to require a timely, accurate, and complete response to the commissioner is provided by Subsections 31A-2-202(4) and (6).

R590-192-2. Purpose.

This rule sets forth minimum standards for the investigation and disposition of accident and health insurance claims arising under policies or certificates issued in the State of Utah. These standards include fair and rapid settlement of claims, protection of claimants under insurance policies from unfair claims settlement practices, and the promotion of the professional competence of those engaged in processing of claims. The various provisions of this rule are intended to define procedures and practices which constitute unfair claim practices and responses to the commissioner. This rule is regulatory in nature and is not intended to create a private right of action.

R590-192-3. Applicability and Scope.

(1) This rule applies to all accident and health insurance policies, as defined by Section 31A-1-301.

(2) This rule incorporates by reference 29 CFR 2560.503-1, excluding 2560.503-1(a).

R590-192-4. Definitions.

For the purpose of this rule the commissioner adopts the definitions as set forth in Section 31A-1-301, 29 CFR 2560.503-1(m), and the following:

(1)(a) "Adverse benefit determination" means, for an accident and health insurance policy other than a health benefit plan, any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise experimental or investigational or not medically necessary or appropriate; and

(b)(i) "Adverse benefit determination" means, for a health benefit plan:

(A) based on the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, the:

(I) denial of a benefit;

(II) reduction of a benefit;

(III) termination of a benefit; or

(IV) failure to provide or make payment, in whole or part, for a benefit; or

(B) rescission of coverage.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a health benefit plan;

(B) failure to provide or make payment, in whole or part, for a benefit resulting from the application of a utilization review; and

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(2) "Claim File" means any record either in its original form or as recorded by any process which can accurately and reliably reproduce the original material regarding the claim, its investigation, adjustment and settlement.

(3) "Claim Representative" means any individual, corporation, association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim, whether or not licensed within the State of Utah to do so.

(4) "Claimant" means an insured, or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy.

(5) "Ongoing" or "Concurrent care" decision means an insurer has approved an ongoing course of treatment to be provided over a period of time or number of treatments.

(6) "Days" means calendar days.

(7) "Documentation" means a document, record, or other information that is considered relevant to a claimant's claim because such document, record, or other information:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; and

(c) in the case of an insurer providing disability income benefits, constitutes a statement of policy or guidance with respect to the insurer concerning the denied treatment option or benefit for the insured's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(8) "General business practice" means a pattern of conduct.

(9) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverage afforded by an insurance policy.

(10) "Medical necessity" means:

(a) health care services or product that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract; and

(b) when a medical question-of-fact exists, medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For an intervention not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For an established intervention, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(11) "Notice of Loss" means that notice which is in accordance with policy provisions and insurer practices. Such notice shall include any notification, whether in writing or other means, which reasonably apprizes the insurer of the existence of or facts relating to a claim.

(12) "Pre-service claim" means any claim for a benefit under an accident and health policy with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(13) "Post-service claim" means any claim for a benefit that is not a pre-service claim or urgent care claim.

(14) "Scientific evidence" is:

(a)(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes;

(b) scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(15) "Urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination:

(a) could seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or

(b) in the opinion of a physician with knowledge of the insured's medical condition, would subject the insured to severe pain that cannot

be adequately managed without the care or treatment that is the subject of the claim.

R590-192-5. File and Record Documentation.

Each insurer's claim files are subject to examination by the commissioner. To aid in such examination:

(1) Sufficient detailed documentation shall be contained in each claim file in order to reconstruct the benefit determination, and the calculation of the claim settlement for each claim.

(2) Each document within the claim file shall be noted as to date received, date processed and notification date.

(3) The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide:

(a) the claim number;
(b) copy of all applicable forms;
(c) date of loss;
(d) date of claim receipt;
(e) date of benefit determination;
(f) date of settlement of the claim; and
(g) type of settlement indicated as:
(i) payment, including the amount paid;
(ii) settled without payment; or
(iii) denied.

R590-192-6. Disclosure of Policy Provisions.

(1) An insurer, or the insurer's claim representative, shall fully disclose to a claimant the benefits, limitations, and exclusions of an insurance policy which relate to the diagnoses and services relating to the particular claim being presented.

(2) An insurer, or the insurer's claim representative, must disclose to a claimant provisions of an insurance policy when receiving inquiries regarding such coverage.

R590-192-7. Notice of Loss.

(1) Notice of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule.

(2) Notice of loss may be given to the insurer or its claim representative unless the insurer clearly directs otherwise by means of policy provisions or a separate written notice mailed or delivered to the claimant.

(3) Subject to policy provisions, a requirement of any notice of loss may be waived by any authorized claim representative of the insurer.

(4) The general business practice of the insurer when accepting a notice of loss or notice of claim shall be consistent for all policyholders in accordance with the terms of the policy.

R590-192-8. Notification.

(1) The insurer shall provide notification of the benefit determination to the claimant which includes:

(a) the specific reason or reasons for the benefit determination, adverse or not;

(b) reference to the specific plan provisions on which the benefit determination is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(d) a description of the insurer's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring civil action.

(2) For a health benefit plan, except for a grandfathered health benefit plan as defined in 45 CFR 147.140, a notice of adverse benefit determination shall provide:

(a) starting with the plan year that begins on or after July 1, 2011:

(i) sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount, if applicable; and

(ii) notification of assistance available at the Utah Insurance Department, Office of Consumer Health Assistance, Suite 3110, State Office Building, Salt Lake City UT 84114; and

(b) starting with the plan year that begins on or after January 1, 2012:

(i) the availability, upon request, of the diagnosis code and treatment code with the corresponding meaning for each; and

(ii) the content in a culturally and linguistically appropriate manner as required by 45 CFR 147.136 (e).

(3) An insurer and the insurer's claim representative, in the case of a failure by a claimant to follow the individual or group health plan's procedures for filing a pre-service claim, shall notify the claimant, of the failure and provide the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant as soon as possible, but not later than five days, or 24 hours for a claim involving urgent care, following the failure. Notification may be oral, unless written notification is requested by the claimant.

(4) Disability income adverse benefit determinations must:

(a) if an internal rule, guideline, protocol, or other criterion was relied upon in making the adverse determination, provide either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(b) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the insured's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(5) Urgent care adverse benefit determination must:

(a) provide written or electronic notification to the claimant no later than three days after the oral notification; and

(b) provide a description of the expedited review process applicable to such claims.

R590-192-9. Minimum Standards for Claim Benefit Determination and Settlement.

(1) All benefit determination time limits begin once the insurer receives a claim, without regard to whether all necessary information was filed with the original claim. If the insurer requires an extension due to the claimant's failure to submit necessary information, the time for making a decision is tolled from the date the notice is sent to the claimant through:

(a) the date that the claimant provides the necessary information; or

(b) 48 hours after the end of the period afforded the claimant to provide the specified additional information.

(2) Urgent Care Claims:

(a) In a case of urgent care, an insurer shall notify the claimant of the insurer's benefit decision, adverse or not, as soon as possible, taking into account the medical exigencies of the situation, but no later than 72 hours after the receipt of the claim.

(b) It is the insurer’s duty to determine whether a claim is urgent based on the information provided by the claimant. If the claimant does not provide sufficient information for the plan to make a decision, the plan must notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information that is required. The claimant shall be given reasonable time, but not less than 48 hours, to provide that information.

(ii) The insurer must notify the claimant of the insurer's decision as soon as possible but not later than 48 hours after the earlier of the plan's receipt of the requested information or the end of the time given to the claimant to provide the information.

(3) Concurrent Care Decision:

(a) Reduction or termination of concurrent care:

(i) Any reduction in the course of treatment is considered an adverse benefit determination.

(ii) The insurer must give the claimant notice, with sufficient time to appeal that adverse benefit determination and sufficient time to receive a decision of the appeal before any reduction or termination of care occurs.

(b) Extension of concurrent care:

(i) A claimant may request an extension of treatment beyond what has already been approved.

(ii) If the request for an extension is made at least 24 hours before the end of the approved treatment, the insurer must notify the claimant of the insurer's decision as soon as possible but no later than 24 hours after receipt of the claim.

(iii) If the request for extension does not involve urgent care, the insurer must notify the claimant of the insurer's benefit decision using the response times for a post-service claim.

(4) Pre-Service Benefit Determination:

(a) An insurer must notify the claimant of the insurer's benefit decision within 15 days of receipt of the request for care.

(b) If the insurer is unable to make a decision within that time due to circumstances beyond the insurer's control, such as late receipt of medical records, it must notify the claimant before expiration of the original 15 days that it intends to extend the time

and then the insurer may take as long as 15 additional days to reach a decision.

(c) If the extension is due to failure of the claimant to submit necessary information, the extension notice of delay must give specific information about what the claimant has to provide and the claimant must be given at least 45 days to submit the requested information.

(d) once the pre-service claim determination has been made and the medical care rendered, the actual claim filed for payment will be processed according to the time requirements of a post-service claim.

(5) Post-Service Claims:

(a) An insurer must notify the claimant of the insurer's benefit decision within 30 days of receipt of the request for claim.

(b) If the insurer is unable to make a decision within that time due to circumstances beyond the insurer's control, such as late receipt of medical records, it must notify the claimant before expiration of the original 30 days that it intends to extend the time and then the insurer may take as long as 15 additional days to reach a decision.

(c) If the extension is due to failure of the claimant to submit necessary information, the extension notice of delay must give specific information about what the claimant has to provide and the claimant must be given at least 45 days to submit the requested information.

(6) A health benefit plan is required to provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal.

(7) Except for a grandfathered individual health benefit plan as defined in 45 CFR 147.140, an insurer offering an individual health benefit plan shall provide only one level of internal appeal before the final determination is made.

R590-192-10. Minimum Standards for Disability Income Benefit Determination and Settlement.

In the case of a claim for disability income benefits, the insurer shall notify the claimant, of the insurer's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the insurer.

(1) This period may be extended by the insurer for up to 30 days, provided that the insurer determines that such an extension is necessary due to matters beyond the control of the insurer and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the insurer expects to render a decision.

(2) If, prior to the end of the first 30-day extension period, the insurer determines that, due to matters beyond the control of the insurer, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the insurer notifies the claimant prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date at which the insurer expects to render a decision.

(3) Each notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

R590-192-11. Minimum Standards for Responses to the Commissioner.

(1) Every insurer, upon receipt of an inquiry from the commissioner regarding a claim, shall furnish the commissioner with a substantive response to the inquiry within the appropriate number of days indicated by such inquiry. If it is determined by the insurer that they are unable to respond in the time frame requested, the insurer may contact the commissioner to request an extension.

(2) The insurer shall acknowledge and substantively respond within 15 days to any written communication from the claimant relating to a pending claim.

R590-192-12. Unfair Methods, Deceptive Acts and Practices Defined.

The commissioner, pursuant to Subsection 31A-26-303(4), hereby finds the following acts, or the failure to perform required acts, to be misleading, deceptive, unfairly discriminatory or overreaching in the settlement of claims:

(1) denying or threatening the denial of the payment of claims or rescinding, canceling or threatening the rescission or cancellation of coverage under a policy for any reason which is not clearly described in the policy as a reason for such denial, cancellation or rescission;

(2)(a) failing to provide the claimant with a written explanation of the evidence of any investigation or file materials giving rise to the denial of a claim based on misrepresentation or fraud on an insurance application, when such alleged misrepresentation is the basis for the denial.

(b) For a health benefit plan, misrepresentation means an intentional misrepresentation of a material fact;

(3) compensation by an insurer of its employees, producers or contractors of any amounts which are based on savings to the insurer as a result of denying or reducing the payment of claims, unless compensation relates to the discovery of billing or processing errors;

(4) failing to deliver a copy of standards for prompt investigation of claims to the commissioner when requested to do so;

(5) refusing to settle claims without conducting a reasonable and complete investigation;

(6) denying a claim or making a claim payment to the claimant not accompanied by a notification, statement or explanation of benefits setting forth the exclusion or benefit under which the denial or payment is being made and how the payment amount was calculated;

(7) failing to make payment of a claim following notice of loss when liability is reasonably clear under one coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance;

(8) advising a claimant not to obtain the services of an attorney or other advocate or suggesting that the claimant will receive less money if an attorney is used to pursue or advise on the merits of a claim;

(9) misleading a claimant as to the applicable statute of limitations;

(10) deducting from a loss or claims payment made under one policy those premiums owed by the claimant on another policy, unless the claimant consents to such arrangement;

(11) failing to settle a claim on the basis that responsibility for payment of the claim should be assumed by others, except as may otherwise be provided by policy provisions;

(12) issuing a check or draft in partial settlement of a loss or a claim under a specified coverage when such check or draft contains language which purports to release the insurer or its insured from total liability;

(13) refusing to provide a written reason for the denial of a claim upon demand of the claimant;

(14) refusing to pay reasonably incurred expenses to the claimant when such expenses resulted from a delay, as prohibited by this rule, in the claim settlement;

(15) failing to pay interest at the legal rate in Title 15:

(a) upon amounts that are due and unpaid within 20 days of completion of investigation; or

(b) to a health care provider on amounts that are due and unpaid after the time limits allowed under 31A-26-301.6 ;

(16) failing to provide a claimant with an explanation of benefits; and

(17) for a health benefit plan:

(a) failing to allow a claimant to review the claim file and to present evidence and testimony as part of the claim and appeal processes;

(b) failing to provide the claimant, at no cost, with any new or additional evidence considered, relied upon, or generated by the insurer in connection with the claim; or

(c) failing to ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

R590-192-13. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

R590-192-14. Enforcement Date.

The commissioner will begin enforcing the revised provisions of this rule on the effective date.

KEY: insurance law
Date of Enactment or Last Substantive Amendment: December 8, 2011
Notice of Continuation: June 25, 2009
Authorizing, and Implemented or Interpreted Law: 31A-1-301; 31A-2-201; 31A-2-204; 31A-2-308; 31A-21-312; 31A-26-303

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